Complete Summary

GUIDELINE TITLE

Guideline for the management of cancer pain in adults and children.

BIBLIOGRAPHIC SOURCE(S)

Miaskowski C, Cleary J, Burney R, Coyne P, Finley R, Foster R, Grossman S, Janjan N, ay J, Syejala K, Weisman S, Zahrbock C. Guideline for the management of cancer pain in adults and children. Glenview (IL): American Pain Society (APS); 2005. 166 p. (Clinical practice guideline; no. 3). [522 references]

GUIDELINE STATUS

This is the current release of the guideline.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory information has been released.

On April 7, 2005, after concluding that the overall risk versus benefit profile is unfavorable, the U.S. Food and Drug Administration (FDA) requested that Pfizer, Inc voluntarily withdraw Bextra (valdecoxib) from the market. The FDA also asked manufacturers of all marketed prescription nonsteroidal anti-inflammatory drugs (NSAIDs), including Celebrex (celecoxib), a COX-2 selective NSAID, to revise the labeling (package insert) for their products to include a boxed warning and a Medication Guide. Finally, FDA asked manufacturers of non-prescription (over the counter [OTC]) NSAIDs to revise their labeling to include more specific information about the potential gastrointestinal (GI) and cardiovascular (CV) risks, and information to assist consumers in the safe use of the drug. See the FDA Web site for more information.

Subsequently, on June 15, 2005, the FDA requested that sponsors of all non-steroidal anti-inflammatory drugs (NSAID) make labeling changes to their products. FDA recommended proposed labeling for both the prescription and over-the-counter (OTC) NSAIDs and a medication guide for the entire class of prescription products. All sponsors of marketed prescription NSAIDs, including Celebrex (celecoxib), a COX-2 selective NSAID, have been asked to revise the labeling (package insert) for their products to include a boxed warning, highlighting the potential for increased risk of cardiovascular (CV) events and the well described, serious, potential life-threatening gastrointestinal (GI) bleeding associated with their use. FDA regulation 21CFR 208 requires a Medication Guide to be provided with each prescription that is dispensed for products that FDA

determines pose a serious and significant public health concern. See the FDA Web site for more information.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Cancer pain (acute and chronic)
- Procedure-related pain

GUIDELINE CATEGORY

Evaluation
Management
Prevention
Treatment

CLINICAL SPECIALTY

Anesthesiology
Family Practice
Geriatrics
Internal Medicine
Nursing
Oncology
Pediatrics
Pharmacology
Psychology
Radiation Oncology
Surgery

INTENDED USERS

Advanced Practice Nurses
Nurses

Pharmacists
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians

GUIDELINE OBJECTIVE(S)

- To provide evidence-based recommendations that, if followed, will help ensure the appropriate assessment and management of cancer pain
- To improve the quality of care that cancer patients receive throughout the course of their disease and treatment

TARGET POPULATION

Adults and children with cancer pain

INTERVENTIONS AND PRACTICES CONSIDERED

Assessment of Cancer Pain

1. Universal screening of cancer patients for presence of pain using a valid scale
2. Comprehensive pain assessment including
    - A detailed pain history
    - A psychological assessment
    - A physical and neurological examination
    - A diagnostic evaluation for signs and symptoms associated with common cancer pain presentations and syndromes
3. Ongoing reassessment of pain
4. Appropriate strategies for pain assessment in special and high-risk populations, such as infants and children, older persons, the cognitively impaired, known and suspected substance abusers, non-English speaking persons, patients at the end of life
5. Assessment of common cancer pain presentations and symptoms

Management of Cancer Pain

1. Anticipate need for pain management by providing patient with prescription for analgesic and instructions to fill and use when pain occurs
2. Initial treatment
    - Base on severity of pain as reported by patient
    - Rapid or slow titration of opioids
3. Ongoing treatment (long-acting opioids with as-needed immediate release opioids for break-through pain)
4. Pharmacologic strategies
    - Nonopioid analgesics, including acetaminophen, non-steroidal anti-inflammatory drugs (NSAIDs)
    - Opioid analgesics, including full, partial, and mixed agonists; agonist-antagonists
    - Coanalgesics, including anticonvulsants, antidepressants, antiarrhythmics, corticosteroids, N-methyl-d-aspartate (NMDA) antagonists, sympatholytic agents, topical agents

5. Patient education about the cause(s) of their pain, the types of and rationale for their analgesic medication, specific instructions on how to dose and titrate their medication, how to manage side effects, when and how to use nonpharmacologic approaches for pain management
6. Psychological strategies, including hypnosis or relaxation, cognitive-behavioral methods, supportive therapy
7. Physical strategies, including application of heat and cold, massage, exercise, Transcutaneous Electrical Nerve Stimulation (TENS), acupuncture
8. Other strategies discussed include nerve blocks, surgical strategies, radiation therapy, and chemotherapy
9. Special considerations for pain management in specific populations, including older patients, substance abusers, and patients at the end of life

Management/Prevention of Procedure-Related Pain in Children and Adults

1. Pharmacologic strategies, including local anesthetics, opioids, benzodiazepines, ketamine, and barbiturates
2. Sedation, including conscious and deep sedation and general anesthesia
3. Non-pharmacologic approaches, including hypnosis, breathing exercises, and imagery

MAJOR OUTCOMES CONSIDERED

- Prevalence and severity of pain
- Morbidity related to cancer pain
- Barriers to effective cancer pain management
- Effectiveness and safety of pain relief measures
- Adverse effects and complications of treatment
- Strengths and limitations of pain assessment instruments

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The guideline development process combined a review of the scientific evidence with the judgment of experts in the management of pain. A comprehensive literature review was conducted to locate systematic evidence reviews and other pertinent literature published since 1994, the year the Agency for Health Care Policy and Research (AHCPR) now known as the Agency for Healthcare Research and Quality (AHRQ) published Management of Cancer Pain, its cancer pain guideline. This evidence was used to develop the recommendations in this revised guideline.

Four sources of evidence were used in the development of this guideline: (a) a review sponsored by AHRQ and conducted by Drs. Joseph Lau and Daniel Carr of the New England Medical Center Evidence-based Practice Center (EPC); (b) other published systematic reviews; (c) evidence reviews commissioned by American Pain Society (APS); and (d) evidence reviews conducted by APS panel and staff members. Reviews from (a) and (b) are listed in Table 3 in the original guideline document.

AHRQ selected cancer pain for an evidence review in response to a request from APS. The New England Medical Center EPC staff, along with members of a panel of technical experts from seven professional organizations, developed the questions for the systematic review of the best available evidence. A search of MEDLINE, Cancer Lit, and Cochrane Controlled Trials Registry databases from 1966 to December 1998 was performed, using a sensitive search strategy for English-language human studies. This review provided the initial evidence for the recommendations in this guideline.

APS commissioned six reviews from Dr. Linda Tyler and her colleagues at the Utah Drug Information Service, University of Utah Health Sciences Center, which are identified in Table 4 in the original guideline document. APS commissioned two reviews from Dr. Daniel Carr of the New England Medical Center EPC, which focused on the management of procedure-related pain and the management of opioid-induced side effects.

APS commissioned from Dr. Mark Jensen, Department of Rehabilitation Medicine, University of Washington School of Medicine, a review of cancer pain measurement tools used by adults. The review protocol for the evaluation of measurement instruments was an adaptation of the protocol used by APS panel and staff for their systematic reviews. The standards for educational and psychological testing were used to define the appropriate psychometric properties to evaluate the instruments. All APS-commissioned reviews are listed in Table 4 in the original guideline document.

Ten reviews were completed by the APS panel and staff members (see Table 5 in the original guideline document).

The databases, dates searched, and review methods used are described in each published evidence review. Reviews conducted by the APS panel and staff members and the Utah Drug Information Service included the following databases and dates: MEDLINE (1966-March 2004), CINAHL (1982-March 2004), Embase (1988-March 2004), PubMed (1966-March 2004), Healthstar (1975-2000), Current Contents (2000-March 2004), Web of Science (1980-March 2004), PsychInfo (1887-March 2004), and the Cochrane database (1993-March 2004). The reading of abstracts helped identify research reviews and articles. Case reports, letters to the editor, articles describing diagnostic techniques, and animal studies were excluded from the reviews. Case reports are cited in the guideline if no other published studies were found. The review and evaluation of all studies followed a specific protocol.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)
Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

The type of evidence for recommendations related to interventions was ranked ordinally in categories from I to V as follows:

I. Meta-analysis of multiple well-designed controlled studies
II. Well-designed experimental studies
III. Well-designed, quasi-experimental studies, such as nonrandomized controlled, single-group pre-post, cohort, time series, or matched-case controlled studies
IV. Well-designed nonexperimental studies, such as comparative and correlational descriptive and case studies
V. Case reports and clinical examples

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

The evidence was classified by type and strength. The type of evidence for recommendations was ranked ordinally in categories from I to V.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The guideline development process combined a review of the scientific evidence with the judgment of experts in the management of pain.

The panelists based recommendations labeled A or B primarily on the evidence. For recommendations labeled C or D, the panel used the available empiric evidence but based its recommendations primarily on expert judgment. The term panel consensus was used when the recommendation was a statement of panel opinion regarding desirable practice.

The classification of evidence described below relates primarily to studies of interventions. When the issue related to documenting the existence of a phenomenon such as the prevalence of various types of pain, well-designed descriptive studies (type IV evidence) were used as evidence. Table 6 in the original guideline document summarizes the scientific evidence for cancer pain

management in adults, and Table 7 in the original guideline document summarizes it for children.

The interdisciplinary panel that developed this edition has expertise in various aspects of cancer pain management. Multiple drafts of the document were prepared by panel members and American Pain Society (APS) staff.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

The evidence for the recommendations was summarized according to its strength and consistency. Strength of evidence ranged from A (the strongest evidence) to D (little or no evidence, or type V evidence only). The strength and consistency of the recommendations are as follows:

A. There is evidence of type I or consistent findings from multiple studies of types II, III, or IV.
B. There is evidence of types II, III, or IV, and findings are generally consistent.
C. There is evidence of types II, III, or IV, but findings are inconsistent.
D. There is little or no evidence, or there is type V evidence only.

Panel Consensus: Practice recommended based on the opinions of experts in pain management.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Two drafts underwent peer review (see Appendix C in the original guideline document for a list of peer reviewers), with the reviewers using an evaluation form based on the Institute of Medicine's "Attributes of a Good Guideline" from Guidelines for Clinical Practice: From Development to Use.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

These recommendations are presented in abbreviated form. Readers should refer to the text of the guideline document for a detailed discussion of each of the following topics.

Definitions for the type of evidence (I, II, III, IV, V) and the strength and consistency of evidence grades (A, B, C, D, Panel consensus) are provided at the end of the Major Recommendations field.

An Overview of Cancer Pain

1. Assess patients with cancer for all types of acute and chronic pain and select appropriate treatment regimens that are based on the underlying mechanisms causing the pain. (Panel Consensus)
2. Reassure patients and family caregivers that most cancer pain can be relieved safely, quickly, and effectively. (A)
3. Prepare clinicians, through both basic and ongoing professional education, to assess and manage cancer pain effectively. (Panel Consensus)
4. Make patient and family caregiver education about pain management a part of the treatment plan, and encourage patients and family caregivers to participate actively in pain management. (A)
5. Collaborate with patients and family caregivers, taking costs and availability of treatment options into account, when selecting pain management strategies. (Panel Consensus)

Assessment of Cancer Pain

6. Perform a comprehensive pain assessment of all cancer patients at each outpatient visit or hospital admission, and use each patient's self-report as the foundation for the assessment. (A)
7. Include in the comprehensive pain assessment a detailed history to determine the presence of persistent and breakthrough pain and its effects on function, a psychosocial assessment, a physical examination, and a diagnostic evaluation of signs and symptoms associated with common cancer pain presentations and syndromes. (B)
8. Use valid pain assessment tools to evaluate, at regular intervals, both pain intensity and the effectiveness of the pain management plan; document these reassessments. (A)
9. Teach patients and family caregivers how to complete a pain management diary in order to maintain the continuity of effective pain management across all settings. (B)
10. Perform a comprehensive pain assessment and diagnostic evaluation and modify the pain management plan when a change occurs in the patient's pain or when a new pain occurs. (B)
11. Use appropriate strategies to assess pain in special patient populations, including the very young and the very old, the cognitively impaired, known or suspected substance abusers, and non-English-speaking persons. (A)
12. Pay particular attention to the preferences and needs of patients whose education or cultural traditions may affect communication about pain. (B)
13. Assess for the common cancer pain presentations and syndromes because prompt diagnosis and treatment may minimize the morbidity associated with unrelieved pain. (B)

Cancer Pain Management

14. Develop a systematic approach to cancer pain management and teach patients and family caregivers how to use effective strategies to achieve optimal pain control. (B)
15. Provide cancer patients with a prescription for an analgesic medication (e.g., hydrocodone and acetaminophen, oxycodone with acetaminophen) and instruct patients to have the prescription filled, to take the medication if

unexpected pain occurs, and to call their healthcare provider for an appointment to evaluate the pain problem. (Panel Consensus)
16. Base the initial treatment of cancer pain on the severity of the pain the patient reports. (B)
17. Begin a bowel regimen to prevent constipation when the patient is started on an opioid analgesic. (B)
18. Administer a long-acting opioid on an around-the-clock basis, along with an immediate-release opioid to be used on an as-needed basis, for breakthrough pain once the patient's pain intensity and dose are stabilized. (A)
19. Do not use meperidine in the management of chronic cancer pain. (B)
20. Adjust opioid doses for each patient to achieve pain relief with an acceptable level of side effects. (A)
21. Avoid intramuscular administration because it is painful and absorption is not reliable. (B)
22. Use optimally titrated doses of opioids and maximal safe and tolerable doses of coanalgesics through other routes of administration before considering spinal analgesics. (Panel consensus)
23. Monitor for and prophylactically treat opioid-induced side effects. (B)
24. Titrate naloxone, when in the rare instance it is indicated for the reversal of opioid-induced respiratory depression, by giving incremental doses that improve respiratory function but do not reverse analgesia. (B)
25. Provide patients and family caregivers with accurate and understandable information about effective cancer pain management, the use of analgesic medications, other methods of pain control, and how to communicate effectively with clinicians about unrelieved cancer pain. (A)
26. Provide patients with a written pain management plan. (B)
27. Clarify myths and misconceptions about pain and pain management and reassure patients and family caregivers that cancer pain can be relieved and that addiction and tolerance are not problems associated with effective cancer pain management. (B)
28. Use cognitive and behavioral strategies as part of a multimodal approach to cancer pain management, not as a replacement for analgesic medications. (B)

Management of Procedure-Related Pain in Children and Adults

29. Treat procedure-related pain prophylactically with appropriate analgesics and/or sedation. (A)
30. Provide patients with information about the expected quality and duration of the sensations that they will experience during a painful procedure. (A)
31. Provide safe, monitored procedural sedation to children and adults who experience distress from painful procedures associated with the diagnosis and treatment of cancer. (B)
32. Offer patients who decline to have procedural sedation nonpharmacologic alternatives to decrease procedure-related pain. (A)

Quality Improvement in Cancer Pain Management

33. Implement a formal process to evaluate and improve the quality of cancer pain management across all stages of the disease process and across all practice settings. (B)

34. Designate one person in each practice setting who is responsible for pain management. (C)
35. Evaluate the quality of cancer pain management at points of transition in the provision of services (e.g., from the hospital to home) to ensure that optimal pain management is achieved and maintained. (B)

Definitions:

Type of Evidence

I. Meta-analysis of multiple well-designed controlled studies
II. Well-designed experimental studies
III. Well-designed, quasi-experimental studies, such as nonrandomized controlled, single-group pre-post, cohort, time series, or matched-case controlled studies
IV. Well-designed nonexperimental studies, such as comparative and correlational descriptive and case studies
V. Case reports and clinical examples

Strength and Consistency of Evidence

A. There is evidence of type I or consistent findings from multiple studies of types II, III, or IV.
B. There is evidence of types II, III, or IV, and findings are generally consistent.
C. There is evidence of types II, III, or IV, but findings are inconsistent.
D. There is little or no evidence, or there is type V evidence only.

Panel Consensus: Practice recommended based on the opinions of experts in pain management.

CLINICAL ALGORITHM(S)

The original guideline contains algorithms for:

- Assessment of Cancer Pain
- Initial Treatment of Cancer Pain
- Rapid Titration with Short-Acting Oral or Intravenous Opioids
- Slow Titration with Short-Acting Oral Opioids
- Ongoing Treatment of Pain in Patients with Cancer

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The strength and consistency of the evidence supporting the recommendations ranges from A, which is the strongest evidence to D, which indicates there is little or no evidence, or that only type V (i.e., case reports and clinical examples) exists. In the absence of level A or B evidence, the panel used the available empirical evidence, but based its recommendation primarily on expert judgment. In these instances, the term, "Panel consensus," was used.

The type of evidence and/or expert judgment supporting each recommendation is identified and graded in the "Major Recommendations" field of this summary.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

General Potential Benefits

- Appropriate assessment and management of cancer pain and prevention of procedure-related pain
- Improved quality of care in cancer patients
- Minimized morbidity associated with unrelieved pain

POTENTIAL HARMS

Adverse Effects of Medication

- See sections titled "Pharmacologic Strategies" and "Coanalgesics" in Section IV of the original guideline for detailed information about side effects of specific medications, including information on opioid tolerance, physical dependence, and addition, and suggestions for preventing opioid-induced side effects.
- See Table 15 in the original guideline document for general comments and cautions regarding the use of opioid analgesics.

CONTRAINDICATIONS

CONTRAINDICATIONS

- Patients who receive a full opioid agonist should not be given a mixed agonist-antagonist because it can precipitate a withdrawal syndrome and cause increased pain
- Rectal suppositories are contraindicated if lesions of the rectum or anus are present and if the patient is neutropenic or thrombocytopenic
- Repetitive intramuscular and subcutaneous injections should be avoided because they are painful and absorption is inconsistent. In addition, they may cause bleeding in patients with thrombocytopenia or coagulopathies
- Carbamazepine is contraindicated in patients with leukocyte counts below 4000 or in patients with an absolute neutrophils count of 1500 or less. Patients at risk for bone marrow failure should not be given this medication
- Cold should not be applied to tissue damaged by radiation therapy, and it is contraindicated for any condition in which vasoconstriction increases symptoms, such as in peripheral vasoocclusive disease, Raynaud's phenomenon, or other vascular or connective tissue diseases
- Radiopharmaceuticals are contraindicated when there is both epidural disease and vertebral metastases
- Aspirin is contraindicated in children in the presence of fever or other viral disease because of its association with Reye's syndrome.

- Mexiletine slows cardiac conduction and is contraindicated in patients with second- and third-degree heart block, severe congestive heart failure, or abnormal liver function tests.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- Any recommendations made by the authors must be weighed against the clinician's own clinical judgment, based on but not limited to such factors as the patient's condition, the benefits versus the risks of suggested treatment, and comparison with recommendations of pharmaceutical compendia and other authorities.
- Studies are lacking in many areas of cancer pain management in children. Therefore, evidence from postoperative and procedural pain studies as well as cancer pain studies was used to describe the strength of the recommendations for children.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Chart Documentation/Checklists/Forms
Clinical Algorithm
Resources

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Miaskowski C, Cleary J, Burney R, Coyne P, Finley R, Foster R, Grossman S, Janjan N, ay J, Syejala K, Weisman S, Zahrbock C. Guideline for the management of cancer pain in adults and children. Glenview (IL): American Pain Society (APS); 2005. 166 p. (Clinical practice guideline; no. 3). [522 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2005

GUIDELINE DEVELOPER(S)

American Pain Society - Professional Association

SOURCE(S) OF FUNDING

The following companies have contributed to a common APS Guidelines Program Fund that is used for the support of all APS evidence-based clinical practice guidelines:

- Abbott Laboratories (Knoll)
- BASF
- Endo Pharmaceuticals, Inc.
- Faulding Laboratories
- GlaxoSmithKline
- Hoechst Foundation
- Janssen Pharmaceutica
- Knoll Laboratories
- McNeil Consumer Healthcare
- Merck and Co., Inc.
- Pain Therapeutics, Inc.
- Pfizer, Inc.
- Pharmacia and Upjohn
- Purdue Pharma L.P.
- Roxane Laboratories, Inc.
- SmithKline Beecham Pharmaceuticals

GUIDELINE COMMITTEE

Cancer Pain Management Guideline Panel (1999-2004)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Panel Members: Christine Miaskowski, PhD RN FAAN (Co-Chair) Professor and Chair, Department of Physiological Nursing, Leader, Program in Symptom Management and Palliative Care, University of California--San Francisco, San Francisco, CA; James Cleary, MD (Co-Chair) Assistant Professor, Department of Medicine, University of Wisconsin, Madison, WI; Richard Burney, MD, Professor of

Surgery, Section of General Surgery, University of Michigan, Ann Arbor, MI; Patrick J. Coyne, MSN RN, Clinical Nurse Specialist, Medical College of Virginia Hospitals/Virginia Commonwealth University, Richmond, VA; Rebecca Finley, PharmD MS, Chair, Dept of Pharmacy Practice and Pharmacy Administration, Philadelphia College of Pharmacy, University of Sciences in Philadelphia, Philadelphia, PA; Roxie Foster, PhD RN FAAN, Associate Professor, School of Nursing, University of Colorado Health Sciences Center, The Children's Hospital Chair in Pediatric Nursing, Clinical Director, The Children's Hospital Pain Service, Denver, CO; Stuart Grossman, MD (1999-2000), Professor and Director, Neuro Oncology Division, Johns Hopkins University, Baltimore, MD; Nora Anita Janjan, MD, Professor, School of Medicine, M. D. Anderson Cancer Center, University of Texas, Houston, TX; James Ray, PharmD (2003-2004), Coordinator, Palliative Care Consult Service, Hamot Medical Center, Erie, PA; Karen Syrjala, PhD, Director, Biobehavioral Sciences, Fred Hutchinson Cancer Research Center, Seattle, WA; Steven J. Weisman, MD, Professor, Anesthesiology and Pediatrics, Medical College of Wisconsin; Jane B. Pettit, Chair in Pain Management, Children's Hospital of Wisconsin, Milwaukee, WI; Cary Zahrbock, MSW, National Coalition for Cancer Survivorship, Minneapolis, MN

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Individuals involved in drafting clinical practice guidelines are charged by American Pain Society (APS) with the responsibility to develop objective, complete, and balanced guidelines. Financial relationships with commercial companies could conflict with the responsibility when the company's products or services are related to the subject of the guideline. To ensure the integrity of APS and the Clinical Practice Guidelines Program, all participants in the development of clinical practice guidelines must submit a Conflict of Interest Disclosure Form to APS prior to participation in any guideline development activity.

All members of the Cancer Pain Management Guideline Panel have submitted Conflict of Interest Disclosure forms that have been reviewed by the APS Executive Director, who has determined no conflict of interest exists with any individual panel member. In addition, panel members disclosed financial relationships with commercial companies to all other panel members during panel meetings.

Individual panel members currently have or during the past 3 years have had relationships with the following pharmaceutical or biotechnology companies:

Christine Miaskowski. Research grants: Purdue Pharma L.P., Janssen Pharmaceutica, Endo Pharmaceuticals, Inc., Amgen; Speakers' Bureau: Purdue Pharma L.P., Abbott Laboratories, Janssen Pharmaceutica, Endo Pharmaceuticals, Inc., Alza, Ortho Biotech, Merck and Co., Inc.

James Cleary. Research grants: Purdue Pharma L.P., Anesta, Endo Pharmaceuticals, Inc.; Speakers' Bureau: Purdue Pharma L.P., Roxane Laboratories, Inc., Cephalon.

Patrick Coyne. Speakers' Bureau: Purdue Pharma L.P., Janssen Pharmaceutica.

Rebecca Finley. Research grant: Merck and Co., Inc.; Speakers' Bureau: Purdue Pharma L.P.

Roxie Foster. Development grant: Abbott Laboratories; Speakers' Bureau: Abbott Laboratories, Astra.

Nora Janjan. Research grants: Siemens, Ortho Biotech; Protocol panels: Alza, Johnson and Johnson, Medtronic.

Karen Syrjala. Research grants: Roxane Laboratories, Inc., Microsoft; Consultant: Roxane Laboratories, Inc., Microsoft; Speakers' Bureau: Janssen Pharmaceutica.

Steve Weisman. Research grants: Alza, Janssen Pharmaceutica, Endo Pharmaceuticals, Inc.; Consultant: Alza, Janssen Pharmaceutica, Cephalon.

Ada Jacox and Carol Spengler, APS staff and consultants. Funding from the APS Guidelines Program Fund.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: None available at this time.

Print copies: Available from for purchase ($20 nonmembers; $15 members) from the American Pain Society (APS), 4700 W. Lake Avenue, Glenview, IL 60025-1485; Web site, www.ampainsoc.org. Orders can be placed via telephone, (847) 375-4715; fax (847) 375-4777; or visit APS's online store, www.ampainsoc.org.

AVAILABILITY OF COMPANION DOCUMENTS

Implementation tools, including scales for rating pain intensity, a sample pain management diary, and a brief pain inventory are available in the original guideline document.

Electronic copies: None available at this time.

Print copies: Available from for purchase ($20 nonmembers; $15 members) from the American Pain Society (APS), 4700 W. Lake Avenue, Glenview, IL 60025-1485; Web site, www.ampainsoc.org. Orders can be placed via telephone, (847) 375-4715; fax (847) 375-4777; or visit APS's online store, www.ampainsoc.org.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on July 26, 2005. The information was verified by the guideline developer on August 31, 2005.

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